REFERRAL TO KING COUNTY ASTHMA PROGRAM

Public Health
Seattle & King County

Fax this form to:

King County Asthma Program

Public Health – Seattle & King County
Seattle, WA 98122
Fax: (206)205-0525 Phone: (206) 263-8182

To be eligible for the King County Asthma Project, participants must:

- **Have an asthma diagnosis**
- **Live in King County**
- **Low Income**
- **Medicaid Eligible (children only)**

Clinic Name: _____ Date: _____/_____/_____

Person Providing Referral _____ (MD, ARNP, RN, PHN)

Phone: (_____) _____ Fax: (_____) _____

Client's Name: (first) _____ (last) _____

Date of Birth: _____/_____/_____ Age: _____ Gender: M F

If patient is between 0-17 years:

Caregiver's Name: (first) _____ (last) _____

Address: _____ Apt. #:_____

_____

Home: (_____) _____ work: (_____) _____Cell: (_____) _____

Leave a message: Y/N

Interpreter Needed? (Specify language) _____

Note Additional Information:

_____

_____